

Medically unexplained symptoms: the biopsychosocial model found wanting

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The recognition that all illnesses have both mental and physical components and that there is a dynamic relationship between components of systems (general systems theory) led to criticisms of the biomedical model and to the development of the biopsychosocial model of Western medicine.^{1,2} From this model emerged the concept of triple diagnosis, whereby clinicians make diagnoses at three levels, the biological or physical, the personal or psychological and the social and contextual.^{2,3} By understanding relevant factors at all three levels and their interactions, clinicians are better able to treat the whole person—the patient-centred clinical method.⁴

However, McWhinney and other proponents of this idea may have been premature in celebrating a ‘Kuhnian paradigm shift’.² An exploration of the concept of somatization suggests that the biopsychosocial model has not adequately addressed important anomalies associated with the previous biomedical paradigm. The biopsychosocial model is unsatisfactory because it remains essentially within the analytic philosophical tradition. In the ‘interpretivist’ philosophical tradition, human experience is inherently ‘bodily’. We offer a view that allows both patients and clinicians to see ‘medically unexplained symptoms’ as unambiguously medical.

PSYCHOSOMATIC ILLNESS: THE EXAMPLE OF BACK PAIN

Consider a patient with chronic back pain that many clinicians would regard as predominantly psychological and social rather than organic in origin. The patient’s greatest risk is that he or she will be regarded as a malingerer, with its offensive suggestion of deliberate lying. In practice most clinicians would avoid such a judgment, preferring to speak of somatization. But this term too is troubling, with its implication that the patient has deceived himself, albeit subconsciously, into a belief that the condition is physical (when its true origin is social or psychological) and is

seeking to gain the collusion of the doctor in this idea. The clinician may then judge the patient as a subtle manipulator, a sort of ‘pseudo-malingerer’, thus tacitly conflating ‘psychosomatic’ with deception. Alternatively, the clinician may feel the patient is in denial or ‘stuck’, in that he or she cannot see that the pain is non-physical in origin.

The doctor then faces a moral dilemma. One option is to acknowledge that the patient has a problem but agree to differ on its cause. Thus, back pain continues to offer the patient a refuge or safe haven; but an objection is that the doctor’s interpretation has negative moral overtones of unconscious deception, lack of insight, or denial. The alternative is for the doctor entirely to reject the ‘reality’ of the symptoms, but this implies doubts about either the patient’s honesty or the validity of the problem—i.e., rejection of the patient. To sustain the doctor–patient relationship doctors frequently accede to the patient’s model, though this may reinforce illness behaviour^{5–7} and legitimize ‘pseudosyndromes’ of the sort that emerge intermittently for social and cultural reasons.⁸

The notion of somatization has to be looked at in a historical context. It is a peculiar expression of the difficulties created by the division between the mental and physical categories contained within the biomedical model and underpinned by the continuing attachment to mind/body dualism, even in the biopsychosocial model^{9,10}—a legacy of attempts within the analytic philosophical tradition to break down complex phenomena in the hope of finding meaning in the simpler constituents (reductionism). Even though the biopsychosocial model emphasizes the importance of understanding the patient’s experience, the philosophical basis is essentially mechanistic: it excludes the centrality of the patient’s experience in distinguishing *illness* from disease and neglects the distinction between pain as an essentially physical response and *suffering*, with its irreducibly experiential and cognitive elements. Yet the clinical virtues of compassion and care are addressed precisely to these experiential matters. It is the experiences of suffering and disability that cause people to seek help from their doctors and drive medicine’s concern to respond.

AN ALTERNATIVE ‘INTERPRETIVE’ APPROACH

An alternative to the analytic philosophical approach that underpins the biomedical and biopsychosocial paradigms is

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found in the interpretive approach. The interpretive goal is to understand the whole experience as a complex unity, embedded in (and hence partly characterized by) a specific context or frame of reference. This approach acknowledges the subjective elements of science (in both theory-forming and observational experience), focuses on interpreting and understanding experience in context and looks at individual and group interpretations of reality with reference to historical, societal and cultural factors. One such interpretivist approach, that of Dekkers,¹¹ involves a conception of the 'clinical gaze' in which all human experience is understood as having an essentially bodily dimension, since our bodily nature is as important to us as any of the more cerebral features emphasized within the analytic tradition (rationality, personality, language use and so on). Moreover, much of our general experience has an obvious bodily dimension. Affective or emotional experiences such as rage, excitement, dread, impatience or anxiety have typical bodily aspects which seem *constitutive* of those experiences rather than the mere accompaniments that dualistic forms of analytic philosophy would have us believe.

Less obviously but just as importantly, our perceptual experience of the world around us—our judgments of size, distance, position, movement, speed and so forth—have an irreducibly bodily grounding.¹² For Dekkers this recognition extends readily into the moral domain where, for instance, moral abhorrence may have a bodily expression as a form of nausea or disgust,¹¹ and positive moral emotions such as compassion likewise have a visceral dimension. That these experiences have an inherently bodily dimension seems to be crucial to our humanity, and in emphasizing this, our argument in this paper is different from an exploration of associations between measurable physiological stimuli and emotional arousal.¹³ For example, unless one experiences the 'gut feeling' of justice and injustice, of hope and hopelessness, then these concepts remain abstract and unreal.¹⁴ Indeed, to say of someone that he is *unmoved* by another's plight is to describe him physically as well as to condemn him morally. Our concern therefore is not to quantify the association (still less any putative causal relation) between mental stimuli and physiological events, but rather to insist upon a unity and identity of 'felt life' and embodied experience. Dekkers distinguishes two senses in which the bodily experience of *illness* has a moral dimension. First, following Parsons,¹⁵ he notes the obligation incumbent upon the sick to cooperate with those who are authorized to supervise their recovery; second, there is the occasional sense of responsibility for the emergence of one's illness in the first place.¹¹

If medicine starts with the patient's experience of bodily suffering and attempts to interpret it, then it legitimately concerns itself with the whole range of sources of normality and pathology, and the absence of a biomedical explanation

for pain does not make the pain suspect. In the interpretive approach, this range is very wide indeed (perhaps threateningly wide for more conservative conceptions of medicine). If the moral dimension of the world is something that above all we experience, then for the interpretive approach, both medical ethics and *medical practice* itself rightly attend to the interpretation of that experience. In this view, the patient's complaints are not to be seen as objective facts, but as phenomena to be interpreted. The meaning of a patient's experiences is no absolute objective phenomenon waiting to be discovered by the patient or doctor.¹⁶

This is indeed an alternative conception of the clinical gaze, and an uncomfortable one. In the analytical view, the concept of somatized illness seems to carry pejorative connotations;¹⁷ moreover, the interpretive layer is at best a kind of icing added to the physical cake. By contrast, for Dekkers the patient is conceived as an embodied self in which the bodily and the moral are fused;¹¹ thus, instead of personal and social life being a pathological intrusion upon the somatic, or the somatic intruding on the psychological and social, *the psychological now becomes an essential mode and expression of the somatic*. Just as nausea may accompany the interpretation of something as disgusting, so back pain is an inherent part of some people's response to their life situation. Thus, the category of somatized illness becomes transformed into an ordinary, even typical, mode of illness expression akin to the suffering of pain or disability, a state with both irreducibly physical and irreducibly experiential and cognitive dimensions. On the theoretical level, for an interpretivist to say that chronic back pain (or indeed any 'medically unexplained' symptom) is somatized illness is to illuminate rather than to dismiss it.

On the practical level, acknowledging the interpenetration of the physical and the moral (sense of meaning) seems to offer great potential to clinical practice: instead of trying to sort out 'real' disease from the rest (in the biomedical model), or to get patients to recognize that their symptoms arise more from personal and contextual than from physical factors (biopsychosocial model), clinicians can focus on helping their patients 'make sense' of their symptoms.

Part of the process of helping patients make sense of their symptoms may include special investigations, but it is also likely to involve helping them consider the meaning of the symptoms in their own lives. The sometimes sterile aim of 'getting patients to see that their recovery lies in focusing on personal and social factors' (a version of reframing) is also avoided because in our view there is no separation in a systems hierarchy. The pain is simply a perfectly valid and integral part of their experience of the world, with the clinical implication that interpreting the personal meaning of the pain may be helpful.

This approach thus provides a satisfactory philosophical underpinning for clinical practices such as exploring patient's explanatory frameworks¹⁸ and their ideas, fears and expectations about their illness, and use of a patient-centred method.^{4,19} Box 1 records an illustrative case.

Box 1 A woman with back pain

A woman of 35 works on a production line near her council estate home. She has four young children and is divorced. One morning she wakes with back pain and is unable to get out of bed. Visiting her at home, her general practitioner (GP) sees that she is upset as well as in pain. Nothing abnormal is found on neurological examination. He prescribes analgesics and advises slow mobilization. Two days later the GP is recalled because of worsening symptoms and during the consultation (attended by the patient's mother and children) she sobs uncontrollably at times. Review of the clinical record reveals frequent consultation over the years for low mood, difficulty in coping and 'somatizing'. The complaints included breast pains, the feeling of a mass in the stomach and multiple gynaecological symptoms. Ten years ago she was treated in general practice with a benzodiazepine and antidepressants. A psychiatrist, to whom she was referred because of panic attacks, taught her relaxation techniques. At this second visit the GP gives her three weeks off work and refers her to a physiotherapist. Three weeks later, the patient requests a third home visit. She is again tearful and in pain and wishes her back to be X-rayed. A further sick-note is issued and new analgesics are prescribed together with an antidepressant 'for its pain-modifying qualities'. The only mention of mood is when the GP says he understands how pain 'can get one down'. Although aware that the best way forward may be to indicate that the pain arises from personal and social factors rather than a physical disorder, he is reluctant to explore this with her for fear she will think her pain is not being taken seriously. He also senses that delving too deeply may diminish her fragile capacity to cope. He agrees to the X-ray and as he predicted it shows no abnormality. The patient is seen three more times over the next month for sick notes and encouragement and then returns to work.

Comment

This clinician went some way to making a 'three stage diagnosis' in that he identified major problems at the social and psychological levels. However, he perceived that by separating these domains and focusing on the personal and social he might damage his relationship with the patient and leave her feeling undermined. He uncomfortably colluded with the biomedical agenda by arranging an X-ray. A clinical method based on interpretivist philosophy would have started with an intervention that helped the patient explore and identify the personal meaning of her pain. What was the pain saying about her life? The goal would *not* have been to 'put the patient right' on this score (e.g. reframe a biomedical interpretation to a psychological and social one); rather, it would have been to acknowledge her pain as a legitimate component of her experience of the world. The consultation could then have moved on to considering changes that might reduce her experience of the world as 'literally painful'.

CONCLUSION

The biopsychosocial model was proclaimed as a paradigm shift because it apparently resolved the mind-body split. However, with its reliance on systems theory whereby levels in hierarchy (e.g. facet joints, or psychological and social stresses) are seen as influencing each other, it is still based on the Cartesian notion of physical and psychological duality. Thus in somatized (psychosomatic) illness clinicians try to get patients to recognize that they have misinterpreted the level in the system in which their problem is truly located. When patients reject the notion that their pain is not really physical (because they experience it precisely as 'really physical'), doctor-patient relationships can be damaged.

An alternative 'interpretivist' view could account for medically unexplained symptoms as simply a component of a person's interpretation or reaction to their situation in the world. Back pain, for example, may have become more common because the world is changing in a way that makes people more often experience back pain as part of their reaction to the world.²⁰ Pain can thus be seen as equally a social and an individual phenomenon. The role of the clinician is therefore not necessarily to hunt for disordered pathophysiology nor, if none is found, to do an awkward dance of collusion with the patient around the notion of somatized illness, possibly attempting to get him or her to 'reframe' the illness, as systems theory would imply is necessary. Rather, clinicians have an important role as experts in the process of helping patients interpret and make sense of their pain as part of their legitimate experience of the world, and, as such, the interpretivist view provides a more satisfactory philosophical rationale for a patient-centred clinical method.

Apart from anything else, the interpretive view takes away the punitive from the therapeutic. But more importantly, the interpenetration of the physical and the moral occurs in both directions. Gains in moral self-esteem, such as could follow from returning to a socially approved and fully functioning role at the workplace, would on this interpretive view be a natural source of somatic gain and be therapeutic. This view allows both patients and clinicians to see many medically unexplained symptoms as unambiguously medical problems and provides a philosophical basis for the completion of the paradigm shift away from biomedicine to a clinical method that affirms the centrality of patient experience.

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